STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING _____ B. WING _____	R 05/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PLACE OF SOUTH BEND	52654 NORTH IRONWOOD ROAD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the PSR completed on 3/24/11 to the Recertification and State Licensure Survey completed on 2/10/11. This visit was in conjunction with Investigation of Complaint IN00089833. Survey dates: May 04 and 05, 2011 Facility number: 000124 Provider number: 155219 AIM number: 100266730 Survey team: Toni Krakowski, RN TC Vicki Manuwal RN Bobbi Costigan, RN Census bed type: 113 SNF/NF 113 total Census payor type: 20 Medicare 68 Medicaid 25 Other 113 Total Sample: 9 Regency Place of South Bend was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the PSR to the Recertification and State Licensure Survey.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Quality review completed on May 6, 2011 by Bev Faulkner, RN	{F 000}		